INSTITUTE FOR Oral Health

Oral Health in Healthcare Reform

Driving Change for America's Underserved Populations

WHITEPAPER

Institute for Oral Health 2010 Focus Groups on "Oral Health in Healthcare Reform"

Focus Group #1 - February 2010 - Washington, D.C.

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Introduction

"When people lose their teeth, it affects how they look and how they feel about themselves. It doesn't make sense to put people through that for a few bucks. Helping people save their teeth is also helping them protect their health."

–Minnesota Dental Association

The Institute for Oral Health (IOH) is an education and collaboration resource, bringing together experts across dental research, education, practice, and policy to help raise awareness on critical concerns and drive changes that advance our profession. Each year IOH focuses on a new theme, and for 2010 we are spotlighting "**Oral Health in Healthcare Reform**" to identify strategies and solutions that help "make the case" for a strong dental presence in healthcare reform and provide more effective access, treatment, and care delivery for the many millions of underserved Americans.

In exploring opportunities for influencing healthcare reform, we are revisiting themes from previous years to highlight high-risk populations who have the most to gain from improvements in our care system –including seniors, children, and the epidemic of people with diabetes. This first 2010 IOH focus group looked at the unique needs and challenges of caring for these demographics, and how integrating medical and dental practice can improve the quality and cost of care, and promote better outcomes.

Hosted at the Gaylord National Convention Center in Washington, D.C. on February 25-26, 2010, this panel discussion was led by Institute for Oral Health Director, Mary Ellen Young, RDH, MHA, and featured four nationally recognized dentistry leaders who discussed the following important topics:

- Motivating and training a workforce for geriatric dentistry – To improve oral health in the growing population of seniors, we urgently need to increase the number of providers who are well trained in addressing the unique needs of vulnerable older adults. In addition to including more geriatric training in dental schools, our profession needs to provide incentives and mentoring to motivate young dentists into taking on this challenging, but rewarding, arena of care.

- Delivering integrated, team-centered care – Collaborative community practices bring together oral health professionals with other caregivers, schools and community organizations, social workers, and more to provider better care for underserved populations such as the elderly in nursing homes, the disabled, and low-income families. This team-centered approach helps each caregiver optimize their role to focus care on what they do best, while reducing the costs and logistical burdens they might otherwise absorb on their own. It is a model that puts the patient first, and increases access to quality care for people who need it most.

- Supporting at-risk patients with personalized dental benefits – To help focus resources on populations that could benefit most from regular dental care, Blue Cross Blue Shield of Massachusetts initiated a customized benefits program for people with diabetes, coronary artery disease, and pregnancy. Using claims data mining to identify at-risk patients, they conducted innovative outreach programs to educate patients on oral health concerns related to their condition, and provided personalized benefits to support more frequent prophylaxis and periodontal exams. The program is succeeding on two fronts: significant numbers of at-risk patients are seeking preventive care, and their yearly medical costs have dropped considerably.

- Driving integration with medical care to improve outcomes for diabetics – The rising epidemic of diabetes is making it imperative for oral health professionals to advance their role in early detection and effective management of both diabetes and periodontal disease –which have direct impacts on each other due to the severe risks associated with chronic inflammation. To protect the overall health of patients, providers need to learn more about diabetes; collaborate with physicians on best practices for treatment; and proactively educate patients on how they can best control diabetes and reduce the risk (and costs) of further health complications.

Join us for the 2010 Institute for Oral Health Conference

In follow-up to this year's focus groups, Institute for Oral Health is providing whitepapers and promoting relevant news and research through our website, blog, quarterly newsletters, and participation at health conferences around the nation. Culminating this year's theme is our 5th annual national IOH conference to be held **October 28 & 29, 2010 in Scottsdale, Arizona at the FireSky Resort & Spa**. Learn more and register early for discount rates ~ please visit: WWW.IOHWA.ORG.

About the Institute for Oral Health

The Institute for Oral Health is dedicated to improving oral health in America by bridging the gap between research and everyday dental practice. Serving as a central resource for education and collaboration, IOH brings together nationally recognized experts to focus on important themes of concern in oral health care today, and works to promote innovation and adoption of progressive treatment guidelines, dental plans, and delivery methods.

learn more

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Panel Presentations

Douglas Berkey, DMD, MPH, MS

University of Colorado, School of Dental Medicine; Dental Director, Total Longterm Care of Colorado

Improving Oral Health for Vulnerable Older Adults

For this Institute for Oral Health focus group, Dr. Doug Berkey brought his years of experience as a leader in geriatric dentistry to address key issues affecting seniors that need attention in healthcare reform. He focused on three areas of concern, including:

- Unmet needs and impact of oral health in the elderly
- Workforce training challenges
- PACE program as viable educational and care delivery model

> *"We are in a dangerous time [in healthcare], but also one of opportunity."*
>
> *–Dr. Doug Berkey*

Unmet needs and impact of oral health in the elderly

Having spent much of his career in geriatric dentistry, Dr. Berkey has a keen insight on the near and long term challenges of providing dental care for elderly patients.

- High prevalence for various problems – Over the past 25 years, more and more aging adults are keeping their teeth longer, translating to a higher incidence of dental issues, including functional status deficits such as biting and chewing. In older patients, medical health concerns and poor nutrition often exacerbate deteriorating dental status. In fact, a UK National Diet and Nutrition Survey identified a benchmark in patients 65 years and older: those who have fewer than 20 teeth are more likely to have insufficient vitamin intake due to poor nutrition and reduced functional status (NHANES III, 2003). As such, treatment plans need to be more aggressive, while supporting better systemic health as well.

> *As a national health strategy, Japan's government established the "80-20 Movement", which promotes good oral health care to help ensure that by age 80, all citizens have at least 20 teeth. The program is succeeding through effective communication and enthusiasm across the nation's dental profession.*

  As people get older, we see an increase in untreated caries (coronal and root caries); for example, an NHANES study showed that nearly 33% of men aged 65-74 had untreated caries, and over 45% of men over 85 years went untreated (NHANES III, 1988-94). The result is a rise in periodontal disease in seniors; studies show that about 20-25% of adults aged 65-85 exhibit moderate to severe periodontitis (Albandar, et al; J Periodontol, Jan 1999).

  Furthermore, oral cancer rates are rising, with vital needs often unaddressed in aging atients. Dr. Berkey cited this disease kills one American every hour, is as common as leukemia, and claims more lives than many other types of cancer such as lymphoma, cervical, endocrine and skin cancers.

- Systemic health consequences – Dr. Berkey emphasized that, "Greater efforts are needed to help the "at risk" elderly receive dental services because good oral health can significantly impact overall health." He cited a number of worldwide studies that linked number of teeth and 'well preserved' dental status in seniors to higher survival rates. Other studies identify how life expectancy drops considerably in patients with severe periodontal disease, and that dental cavities have been 'significantly associated' with shorter survival rates. Additionally, a study has shown that those with high tooth loss (keeping <10 teeth) demonstrate two to four times greater risk of dementia.

  On the upside, Dr. Berkey highlighted improved efforts in hospitals and nursing homes wherein by administering daily oral hygiene in elderly patients, they dramatically reduced cases of pneumonia and respiratory infections, as well as pneumonia-related deaths. Studies have shown these interventions to reduce the relative risk by 34 – 83% (EBD 2007:8.4).

  "In terms of policies, these survival issues are compelling reasons for us to be more aggressive in taking care of dental problems in seniors, especially when these patients often don't complain about them."

  –Dr. Doug Berkey

  Adopting a perspective and practice of cross-discipline healthcare is more beneficial for patients, and most likely more cost effective in the long term. Dr. Berkey quoted Dr. Ian Needleman of the UCL Eastman Dental Institute: "*Collaborations between oral health and medical researchers should be mandatory. In view of the potential impact of such simple interventions on the health of individuals, appropriate investigations should be undertaken with urgency*."

Workforce training challenges in geriatric dentistry

As both an educator and clinician in dentistry, Dr. Berkey spotlighted a dangerous gap in dental education and workforce training with respect to geriatrics. He noted that numerous future-of-dentistry reports (from Institute of Medicine, ADA, Surgeon General, and so on) have affirmed that the dental workforce is not adequately prepared to meet the current and future health needs of older adults –often flagged with dramatic terms such as "looming crisis" and "silver tsunami."

In 2008, the Institute of Medicine (IOM) recommended a "three-pronged strategy" to build the workforce needed to support the projected numbers of older adults:

1. Enhance geriatric competence of the ENTIRE workforce – The IOM's proposed approach includes infusing pre/postdoc curriculum with geriatric training and standardizing learning experiences with settings, techniques, and mentoring on caring for older adults. The goal is to teach providers to address the broader spectrum of geriatric needs beyond dental problems, including medical challenges and oral-systemic considerations, psychosocial concerns, and issues around access and affordability of care.

   Reports on "21st century dental graduates" cite the need for broader skill sets, including exceptional competence in oral health prevention, promotion, and technical interventions; excellent communication skills and psycho-social understanding, including the ability to work with patients with diminished mental capacity; and deep knowledge of medicine, pharmaceuticals, and drug interactions This comprehensive preparation helps facilitate a necessary convergence to bring together technical skills and clinical decision making with demonstrated ability to motivate and empathize with patients in complex and challenging scenarios.

2. Increase the recruitment and retention of geriatric specialists – A "change agenda" to improve geriatric dentistry includes increasing the number of postdoctoral geriatric training programs. Furthermore, geriatrics should become core curriculum for all general dentistry postdoctoral training programs, and we should explore non-traditional opportunities for training such as partnering with nursing and social workers, venues often used for medical training that could be very helpful for dental education.

   Additionally, providers are encouraged to take advantage of the numerous online educational resources that help raise awareness and expand perspectives on the special needs of geriatric patients.

The Portal of Geriatric Online Education is a free repository of geriatric educational materials in e-learning formats including lectures, virtual patients, case-based discussions, and more. Visit: www.POGOe.com

3. Improve the way care is delivered – While advancing geriatric dental education and training is vitally important, in order to effectively meet the needs of older adults, the dental profession also needs to explore ways to improve the entire care delivery system. We need models that "re-think care for older adults and find cost effective ways to deliver care that do not sacrifice quality." For example, effective geriatric care models include coordinated, interdisciplinary teams to manage multiple medical, dental, and social needs, and offer preventive home visits, transitional care, proactive rehabilitation, and education and support for caregivers (IOM, 2008).

Improving care delivery with the PACE program

One highly effective care model is PACE (Program of All-Inclusive Care for the Elderly), a growing national system of long-term care that provides community based managed care for the frail elderly. Conceived by a dentist in the early 1970's, the PACE model supports aging adults while respecting their 'core wishes' to retain the autonomy of living at home and maintain a maximum level of physical, social, and cognitive function.

PACE supports adults aged 55 and older who live in supported communities, and provides a comprehensive care package, including integrated acute and long-term care; all Medicare and Medicaid services, plus community long-term care; and no benefit limitations, co-payments, or deductibles.

Highlights of the PACE model include:

- Effective integrated team managed care – The inter-disciplinary teams include primary care providers; home care and nursing home providers; hospital staff; lab, x-ray, and medications experts; day health providers such as OT/PT, speech therapists, and nutritionists; and specialists such as geriatric dentists, vision care, and so on.
- Increased nationwide adoption – There are now 70 PACE providers across 33 states. The total number of patients served per year has more than doubled in the past seven years, going from 671 patients in 2002 to 1,645 in 2009 within the Colorado program, predominantly focusing on care for frail adults aged 80-90.

- Improved experience for patients, providers and payers – The PACE model allows patients to receive comprehensive care while maintaining a good quality of life as a functioning member of their community. Additionally, PACE benefits providers by offering "freedom from traditional restrictions" with greater ability to focus on the needs of elderly patients. The model also delivers cost savings for payers such as Medicare and Medicaid, as PACE is working to keep patients out of nursing homes and assisted living facilities for longer periods of time.

- Innovative dental care delivery – Colorado-based Total Long-term Care (TLC), where Dr. Berkey is Dental Director, is part of a PACE program and has seen participant growth of 7-8% for the past several years, with return on equity about 22% (TLC, 2010). The program has enabled them to expand dental provider roles to advance skills and participation of dental assistants and hygienists, and engage 4th year dental students in clinical care for effective geriatric training. Furthermore, the TLC dental team collaborates with primary care providers to help ensure patients get the medical screenings and referrals they need, as well as assessing physical functioning related to oral health such as chewing and swallowing.

Progressive training and care at TLC

Employing the PACE model, Total Long-term Care (TLC) delivers a "rich setting to teach, treat, and replicate" quality geriatric care. With a philosophy that honors aging adults, TLC provides a good example of innovative delivery through interdisciplinary planning and clinical care that regularly monitors outcomes to measure and improve quality.

A key element in TLC's care model includes tools and training for effective clinical decision making based on a range of factors unique to older patients. For example, in addition to weighing patient expectations and the severity of need (relevant to any age level), providers need to consider such factors as the patient's ability to tolerate the stress of treatment; whether or not they can reasonably give informed consent and self-administer pain medications; and even staffing resources to help patients who need physical assistance or might need to be restrained.

"Providing a quality training experience is key. Students are developing and eager, but if they go into an overly negative experience with elders, they may be scared off by all the behavior issues, medical/dental concerns, even a patient's inability to sit in a normal chair. We need to introduce students gently – start with more 'perky' seniors to build confidence for more challenging patient scenarios."

–Dr. Michael Helgeson

The organization places a strong focus on mentoring and easing dental students into understanding the complexities of elder care to help build their confidence and comfort with geriatric dentistry. Additionally, TLC partners with other caregivers and social workers to help manage the myriad of challenges that comes with caring for seniors to comprehensively address their needs.

Michael Helgeson, DDS
Co-Founder and CEO of Apple Tree Dental, Minnesota; Past President, American Society for Geriatric Dentistry; Past President, Special Care Dentistry Association

Oral Healthcare Reform: Older Adults & People with Special Needs

As co-founder of Apple Tree Dental, Dr. Michael Helgeson has helped develop innovative delivery models to bring dental care to underserved populations such as the elderly and disabled in over 100 locations across the state of Minnesota.

The looming crisis of dental budget cuts

In the February 2010 IOH focus group, Dr. Helgeson began by noting that "deep cuts" to Medicaid coverage in 2010 are creating a crisis all over the country, one which we will all see either in our healthcare services or on a personal level as we try to manage care for our parents and grandparents. In the case of special needs patients such as the developmentally disabled and the elderly, these dental budget cuts will severely limit their ability to get regular services for prevention of caries and periodontal disease, and any necessary restorative care to help them maintain a reasonable functioning quality of life.

To illustrate his concern, Dr. Helgeson showed a video produced by the Minnesota Dental Association as a call to action for legislators about the dire consequences of cutting adult dental benefits. For a number of Minnesota dental clinics, the majority of patients rely on Medicare or Medicaid to pay for services. Recent budget cuts have forced some clinics to turn away 6-10 patients per day due to reduced coverage, while other providers are forced to explain to patients that the state will not pay to fix their broken dentures, save their teeth, or prevent the worsening of their gum disease. In essence, these limitations are sentencing a large population of disabled and elderly people to a daily life of pain and discomfort, and setting the stage for severe systemic health concerns, emergency room visits, and higher overall healthcare costs.

> *"When people lose their teeth, it affects how they look and how they feel about themselves. It doesn't make sense to put people through that for a few bucks. Helping people save their teeth is also helping them protect their health."*
>
> *--Minnesota Dental Association "Safety net clinics video", 2010*

Improving policy in Minnesota

To provide a silver lining, a number of initiatives are underway to help offset the dental care coverage crisis, including:

- Pay for services that work – IIntroduce a set of Limited Adult Benefits to cover the most needed services that deliver the best outcomes, while reducing Medicaid spending.
- Target high risk, costly populations – Develop alternative funding sources for the aged, blind and disabled in long-term care, such as paying for dental services with Social Security income using "Incurred Medical Expenses" formulas beyond each state's Medicaid dental program.

- Preserve the safety-net infrastructure – The Critical Access Dental Providers program is helping to create a sustainable network of dental clinics serving special needs patients and others facing barriers to care in underserved urban and rural areas.
- Improve accountability for health outcomes – The state has established a Dental Services Advisory Council comprised of clinical and educational experts, and administrative planners working together to evaluate and incorporate clinical evidence and critical access needs into state healthcare programs.
- Create a more effective workforce – Two new Dental Therapy programs have been established to expand the primary dental care workforce, and create new skill sets that extend the reach of dental programs serving low-income and special needs populations.

The benefits of team-centered care delivery

A common complaint echoed across geriatric dentistry is the need for more integration among all members of the healthcare workforce. By partnering with healthcare providers and caregivers, dental professionals can be more effective in resolving and preventing both oral health and systemic health issues. As an example of the lack of dental care provided to nursing home residents, a 1999 National Nursing Home Survey reported that only 13% of residents had received dental care during their stay, but during 1997, only 9% of residents had a documented record of dental services. Yet regular daily oral care and professional care for these elderly patients could have made a substantial difference in their overall health and quality of life.

"A team approach to care delivery enables you to reach a consensus on what's reasonable and provide world class care that's much less costly than at most other places."

–Dr. Michael Helgeson

In advocating the benefits of a team approach to care delivery, Dr. Helgeson highlighted the successful model of the Mayo Clinic. Founded over 100 years ago, it was the first and still is the largest integrated not-for-profit group practice in the world, with over 3,000 physicians and scientists and 46,000 allied staff serving patients at their clinics in Minnesota, Florida, and Arizona. Fundamentally, the success of the Mayo Clinic model lies in their philosophy of focusing first and foremost on the needs of patients by bringing together every healthcare specialty to pro-actively collaborate in the team diagnosis and treatment of each patient. In this way, they provide a quality care experience that comprehensively addresses the needs of each person. The Mayo model produces world class outcomes at costs dramatically lower than many other health systems.

Successes of Community Collaborative Practice

Some years ago, Dr. Helgeson helped develop a new Oral Healthcare System model in Minnesota focused on creating "an accountable system of care that will improve oral health" for populations relying on public funding. The system's team-centered approach achieves the following:

- Effectively partners numerous stakeholders including professional dental organizations, community clinics and "safety net" providers (i.e., caregivers who catch those who typically fall through the cracks), educational and community action programs, health plans, state agencies, and advocacy groups.
- Ensures multiple perspectives are represented and that evidence-based decisions are made by having the system managed by a balanced group of stakeholders.

- Provides a process for validating scientific advice on policy through a clinical advisory board of credentialed experts.
- Expands the Community Collaborative Practice model by transforming safety-net clinics into Oral Healthcare Centers designed to reach people where they live, work or go to school, and serve them while they are still healthy and help them stay healthy, rather than waiting to serve them until after their oral infections spread and teeth are lost. Oral Healthcare Centers provide outreach programs and onsite services by collaborating with schools, Head Start Centers, and nursing facilities to proactively increase dental care awareness, early diagnosis and treatment among the population groups at highest risk for mouth infections.

Community Collaborative Practice is a method of reaching the underserved 30% of our population who face financial and other barriers to dental care. Dr. Helgeson pointed out that, in addition to limited financial resources, underserved people often do not access care because they lack the knowledge to seek care before problems arise, or their disabilities or compromised health status makes it too difficult to travel or be accommodated at traditional dental clinics. This community-driven model overcomes barriers through effective, multi-disciplinary collaboration, funded by a sustainable mix of public, private and philanthropic resources and proactively delivering earlier education, detection and treatment to at-risk population groups.

How Community Collaborative Practice reduce costs

Community Collaborative Practice is a sustainable, cost-effective model because it:

- Provides less costly education, prevention, and oral health assessment – It is about half as costly for a hygienist to provide these services in a community setting than for a dentist in a traditional clinic.
- Optimizes the roles of all care providers – This model enhances the roles of dental and medical professionals, and engages teachers, social workers, and other staff at community sites in new roles that enhance oral health.
- Optimizes the frequency of preventive care, based on risk assessment – Rather than providing checkups for healthy people every six months, this model delivers more frequent checkups for at-risk patients until their mouth infections are under control, and less frequent checkups for low-risk individuals.
- Reduces the use of ineffective treatments – A Clinical Advisory Board reviews scientific evidence so that ineffective treatments can be discontinued and those that work well can be increased.
- Reduces downstream medical and transportation costs – Particularly for people with special needs, the onsite care delivery helps eliminate travel barriers, and prevents the need for costly emergency room visits and hospitalizations.

"Collaborative practice is also cost-effective because the group provides checks and balances to avoid over-treating. When the group advises against costly procedures, families more easily understand and accept it, whereas in traditional models they hear advice from numerous providers and struggle to know how to make the right decision."

–Dr. Michael Helgeson

- Reduces administrative costs while improving accountability – The Oral Healthcare System channels all patient and treatment information into one data resource center, providing an integrated model capable of measuring oral health outcomes.

Keys to success

Citing Apple Tree Dental as an example, Dr. Helgeson highlighted some key components that make the Community Collaborative Practice model a success:

- Nonprofit organizational structure – The organizational governance in this model provides an effective way to align accountability with the mission to "improve the oral health of people with special access needs who face barriers to care." The nonprofit model can also deliver front-line services in the community at about half the cost of traditional clinic based models.
- Staff with essential areas of expertise – Expertise in geriatric, pediatric, and special care dentistry is combined with expertise in fundraising and nonprofit development teams; educational collaborations and clinical rotations; and public policy leadership.
- Hub-and-spoke model for community care delivery – At the center of the delivery system is the central clinic and operations center. From the center, year round services are delivered onsite at multiple community locations, with active collaborations that optimize the use of health and education infrastructure, mobile dental delivery systems, and professional staffing.
- Establishing "virtual dental homes" – The Community Collaborative Practice model creates a continuous source of oral health services that provides "culturally competent care focused on patients and families, staffed by an interdisciplinary team linked together using tele-health technologies."
- Deploying advanced mobile dental offices – Apple Tree employs large trucks that can transport multiple sets of complete, compact mobile dental offices that can easily be set up at community locations each day. Apple Tree' mobile dental offices regularly serve people at more than 100 locations across the state of Minnesota from nursing homes to Head Start Centers to schools. On-site delivery costs only about one-third as much as medical transportation, staff time, and family time required to transport elders to traditional dental offices.

"Apple Tree can quickly turn any room, anywhere, into a state of the art dental clinic in less than 15 minutes."

–Appl e Tree Dental video

- Dentists and hygienists in "collaborative practice" – The collaborative practice model integrates dental care in community settings by linking dentists with hygienists. Dentists serve in the role of Dental Director to ensure that every resident receives care; and collaborate with a hygienist who provides prevention, daily care planning, assessment and triage services; and also helps facilitate dentist-patient relationships with other dentists in the community. Hygienists play a new front-line role as "oral health practitioners" triaging and prioritizing follow-up care in collaboration with the Dental Director.

- A sustainable, low-expense model – Apple Tree operates an efficient model, generating a mix of private, public and philantropic revenues, and keeping expenses about 30-40% lower than traditional dental clinics.

Learn more online at appletreedental.org

Maria Emanuel Ryan, DDS, PhD
Professor and Director of Clinical Research, School of Dental Medicine, Stony Brook State University of New York

Special Considerations for Dental Professionals in Managing Patients with Diabetes

Dr. Maria Ryan has dedicated her career to researching the connection between oral health and systemic health, and how prevention and early detection of periodontal diseases can improve overall health outcomes. In particular, she has focused extensively on managing diabetes, currently one of the fastest-growing epidemics in the world, affecting over 24 million Americans, with an additional 57 million with pre-diabetes, and an estimated six million with undiagnosed diabetes. Diabetes is one of the costliest conditions to treat, and in this Institute for Oral Health group discussion, Dr. Ryan emphasized key concerns and strategies that dental practitioners need to consider improving the health of these high risk patients.

Managing a worldwide epidemic

Diabetes is rapidly becoming a pandemic, with over 285 million people affected worldwide –projected to jump to 435 million by 2030. Currently, the most dramatic increases are in China and India, where, as Dr. Ryan noted, there are major concerns that diabetes will "*lock up their entire healthcare system*."

Here at home, one of our biggest problems is what we eat, with obesity being another epidemic concern (affecting over 60% of the U.S. population), and not in isolation but directly related to the onset of diabetes. In fact, type 2 diabetes is "preferentially affecting" the obese African-American and Hispanic populations. This disease is also showing an alarming incidence in children, increasing "10 fold when compared with a decade ago." The chronic inflammation in overweight individuals increases the risk of infection and insulin resistance, which drives the onset of diabetes. Further challenging this equation has been our nation's recession, with economic factors pushing families and individuals to eat as cheaply as possible, which often means fast food. Additionally, increasing "urbanization" is creating a more sedentary culture in the U.S., with more people working indoors at computers and spending free time on TV and video games.

When we look at diabetic patients, the difference in the impact of good vs. poor oral health is significant. Consider the mouth in terms of surface area for inflammation and infection – Dr. Ryan suggested that if this were an open lesion on another part of the body, the patient would attend to it immediately. But because patients often cannot see or recognize oral disease, it may go untreated. In fact, even in pre-diabetic individuals, "acute infections may induce a temporary state of diabetes requiring short-term insulin therapy."

As such, dentists need to be proactive in educating patients about how neglected oral health leads to diseases that get transmitted into the blood stream and affect their other health conditions. In this sense, an ounce of prevention can go a very long way, literally.

"A person is not healthy without good oral hygiene."
–C. Everett Koop, M.D.
Former U.S. Surgeon General

Diabetes and oral health: A two-way street

A critical consideration with diabetic patients is that when inflammation of periodontal disease occurs, their whole health picture changes. Patients then face an increasing chance of pathogens getting into their overall system, leading to escalated blood glucose levels, breakdown of connective tissues, and bone loss. Simply put, Dr. Ryan stressed that if dentists do not treat periodontal disease in diabetic patients, not only does local inflammation occur, but patients will likely experience a systemic inflammatory response –which increases their risk for cardiovascular disease, stroke, and other life-threatening conditions.

"When you think of the best way to manage diabetes, it is a combination of three things: reducing the levels of pathogens; modulating the host response; and reducing risk."

–Dr. Maria Ryan

Dr. Ryan noted that in dentistry, the multi-layered therapeutic strategy for managing diabetic patients is often referred to as "periodontal medicine" as most conditions come from periodontitis in connection with overall health. Substantial evidence exists linking periodontal disease and diabetes, and it is not surprising, when we look at diabetes as a "chronic inflammatory disease", especially in poorly-controlled diabetics who have an increased susceptibility to oral disease. This chronic inflammation "drives all of their long-term complications," and periodontal disease can also impact the level of control in diabetes.

A considerable amount of medical literature and research has addressed the connection between acute infections and diabetes, in particular, the impact of inflammation. Dr. Ryan cited one study that tracked 1,047 subjects over five years, noting that inflammation is measured by the levels of circulating C-reactive protein (CRP), which is associated with insulin sensitivity –even in people without diabetes. This study identified that high CRP levels and other markers of inflammation were significantly related to the development of Type 2 diabetes, and thus, they concluded that chronic inflammation is a new risk factor because it causes insulin resistance.

Increasingly, health education materials are promoting ways to reduce inflammation to avoid the onset of diabetes. In fact, Dr. Ryan highlighted studies she has been involved in and articles that are suggesting that periodontal disease itself is driving the occurrence of diabetes. Left untreated, periodontitis sets the stage for the chronic inflammation and insulin resistance that lead to Type 2 diabetes.

A 20-year Columbia University study tracked over 9,000 people without diabetes. Those with elevated levels of periodontal disease were twice as likely to develop Type 2 diabetes due to chronic inflammation.

– Endocrine Today
Volume 6, Number 20, November 2008

Adopting risk reduction strategies into oral health care

For people with diabetes, a risk reduction strategy is essential because the disease can impact the rate of progression in oral diseases. The best approach starts with risk assessment, and includes working with physicians to help patients get better control of the disease and boost their response to treatment.

"You don't need a lot of bacteria or plaque to get really significant oral disease in a poorly-controlled diabetic."

–Dr. Maria Ryan

Dr. Ryan emphasized:

> "*Risk assessment is something that really needs to be picked up on in dentistry because the risk factors have an impact on the progression and severity of disease, and the patient's response to therapy. If you don't do risk assessment, it becomes very difficult to determine how to manage your patient.*"

Admittedly, this strategy means investing more time on communication with patients –and that is part of where our system is broken. There is no reimbursement for this extra time and care, and thus, it is often hard to make the business case to motivate providers to pursue this important level of care.

Nevertheless, today's dentist can expect to see increasing numbers of patients who have diabetes, detected or undetected. Dr. Ryan recommends partnering with physicians to initiate protocols for managing patients with diabetes, including:

- Identify diabetes symptoms – Learn how to recognize classic signs and symptoms of diabetes, which include excessive thirst (polydipsia), fatigue, unexplained weight loss, increased infections, leg cramps, numbess in the extremities, impotence, and blurred vision.
- Conduct risk assessments – Interview patients about risk factors including any family history of the disease, their racial descent, history of impaired glucose tolerance, their HDL cholesterol levels, any hypertension and obesity concerns, and more. The more complications a diabetic has, the more likely they are to develop other long-term complications, so it is important to ask them about their other conditions.

Dentists can help with early detection of diabetes by screening for classic symptoms and performing a simple fasting or non-fasting plasma glucose test. If levels are greater than 200, they can refer the patient to a physician.

- Determine long-term risk – Ask patients how long they have had diabetes; the longer they have had the disease with not much control, the greater the chances of developing long-term complications.
- Look at existing complications – Find out if the patient has had any of the most common long-term complications (cardiovascular disease; diabetic retinopathy and glaucoma; kidney damage; nerve damage in the feet; and increased infections). Also consider current risk factors including stress, medications, hormonal variations, etc.
- Track gestational diabetes – Document any previous occurrence of diabetes, even if female patients no longer have the disease; 30-50% of women who had it during pregnancy later develop Type 2 diabetes within 10 years.
- Implement therapeutic strategies – Reduce the impact of periodontal disease through therapies that eliminate bacterial infection such as Triclosan toothpaste and antiseptic rinses, topical antimicrobials; or surgical reduction of periodontal pockets. Also consider ways to modulate host response through systemic or local delivery of drugs such as Periostat® or bisphosphonates.
- Adjust oral agents to reduce risk of hypoglycemia – Patients on insulin therapy are susceptible to hypoglycemia, and some oral agents (such as second generation sulfonylureas) induce a "relatively high incidence of hypoglycemia". Consider low risk therapies such as meglitinides, biguanides, or thiazolidinediones. Also, learn to identify

early signs and symptoms of low blood sugar, such as: confusion, shakiness, agitation and anxiety, sweating, dizziness, and accelerated heart rate. For dental providers who treat diabetic patients, it is helpful to have on hand some hard candy or Gluco Tabs, which can be effective emergency treatment if you detect a hypoglycemic reaction.

- Promote risk management for periodontal disease – Educate patients on ways to reduce risk through good oral health strategies such as more frequent dental visits; smoking cessation and weight loss to reduce inflammation; improved nutrition and stress reduction; as well as dental treatment including restorative work to correct any faulty dentistry; and perioceutics to help reduce connective tissue diseases.

Additionally, it is important to remember that dental providers may be the "first line of care", as people often see their dentist more regularly than they see a doctor. As such, if dentists can increase their own awareness about diabetes and in turn, educate physicians about oral health risks, we stand a greater chance of both improving disease management and reducing the onset of diabetes.

Recognizing other oral health risks in diabetics

When advising diabetic patients, dentists need to understand there is much more at work than whether or not a patient brushes and flosses regularly. A primary factor is the patient's level of control over diabetes. Other general trends beyond periodontitis include:

- Increased risk of gingivitis and caries, often because diabetics secrete more glucose through their salivary glands. Additionally, as diabetics have more hypoglycemic events, they often chew on Gluco Tabs, blasting the mouth with high levels of sugar, which drives the onset of caries. Dr. Ryan recommended advising patients to brush their teeth or rinse their mouth after taking Gluco Tabs to help reduce the risk of decay.

- Greater incidence of absesses and enlargement of parotid salivary glands.

- Xerostomia related to glands and medications.

- Burning of the mouth or tongue, which may be exascerbated by candidiasis

"Dentists often dismiss gingivitis because it's reversible –but in diabetic patients, it may be too much disease and needs to be addressed. In general, you need to follow these patients closely and employ multiple therapeutic strategies to reduce risk and help control their diabetes."

--Dr. Maria Ryan

If dentists detect signs of periodontal disease in diabetic patients and are not comfortable treating it, Dr. Ryan stressed that they should refer those patients as appropriate to ensure they get treatment as early as possible.

Additionally, dental professionals need to be proactive about raising awareness with physicians who treat diabetic patients. Often physicians do not recognize that poorly controlled diabetes can promote acute periodontal disease, which can create as much damage to a diabetic's health as those systemic complications that result in amputation. With the epidemic rise of diabetes, it is becoming essential that dental care providers expand their role as "physicians of the mouth" to be more involved in the total care of diabetic patients.

Dr. Ryan emphasized:

> "*Physicians often look for infection and inflammation everywhere in the body except the mouth –but it happens in the mouth and they need to be aware of that. Oral inflammation drives insulin resistance and increases the risk for the diabetic complications they are trying to prevent.*"

She added that dentists and hygienists need to play a major role in early detection, early intervention, maintenance, hygiene, and therapies –for all types of oral disease that may impact diabetes. They can then engage the physician and other caregivers to make sure they understand how the oral health risks can impact the patient's diabetes, and together develop strategies to help control the disease to preserve the health of the patient.

Enlisting the dental profession in diabetes control

It is well known that diabetes creates an increased risk for developing infection, and that infection leads to impaired diabetic control as it hinders the patient's ability to process insulin. Organizations such as the Center for Disease Control (CDC) are increasingly reaching out to the dental profession for help in identifying and managing diabetes through early detection and treatment of periodontal disease. In fact, Dr. Ryan noted that diabetes researchers have told her that if the current trends are not reversed, "*diabetes alone will cripple our healthcare system*."

In recent years, some promising steps forward have been occurring across the country, including:

- March 2007, Atlanta, GA – the CDC hosted sessions to raise awareness such as "Diabetes and Oral Health" Science & Practice"; and "Diabetes an Epidemic: The Role of the Dentist."
- April 2007, Scottsdale, AZ – a panel of independent experts was convened – including dentists, physicians, and leaders from the American Dental Association and American Diabetes Association– to discuss opportunities for partnering on the prevention, treatment, and management of diabetes.
- November 2007, Seattle, WA – the annual Institute for Oral Health conference addressed the theme of periodontal disease and diabetes, with a key focus on dental considerations for optimal medical management of people with diabetes. [To download the whitepaper for this conference, please visit IOHWA.ORG.].
- June 2008 – the American Diabetes Association hosted the first scientific session focused on the prevalence and risk factors of periodontal disease for people with diabetes, which included the key recommendation that all caregivers should ask their diabetic patients when they last had a dental exam and provide referrals.
- October 2008, San Antonio, TX October 2008 in San Antonio, TX, the American Dental Association held a full-day session for a large audience of dentists on how to better manage diabetes in their patients and work with physicians on controlling the disease the American Dental Association held a full-day session for a large audience of dentists on how to better manage diabetes in their patients and work with physicians on controlling the disease.

The future of periodontal medicine

It is important to remember that dental providers are often the "first line of care", with people seeing their dentist more regularly than they see a doctor. As dentists increase their own awareness about diabetes and educate physicians about oral health risks, we stand a greater chance of both improving disease management and reducing the onset of diabetes.

Dr. Ryan emphasized that oral health care needs to become a key component of any diabetes management education and care program, and she identified a number of strategic solutions the dental profession should adopt in order to provide more effective care for diabetic patients, including:

- Develop shared electronic records to better facilitate partnering between physicians and dentists in treating diabetic patients.
- Establish collaborative teams that partner dentists and physicians with integrated treatment plans. For examplephysicans could provide dentists with medical reports on A1c levels, current medications, and patient risk factors. Conversely, dentists could inform physicians about oral health conditions that may impact diabetic control, such as details on a patient's last dental exam and periodontal screenings. Additionally, physicians could help patients reduce risk of complications by recommending they maintain better oral hygiene and seek biannual exams and periodontal treatment as needed. In fact, Dr. Ryan noted collaborative approach could well represent "*the group practice of the future*."
- Create a risk assessment and surveillance tool as part of the medical/dental history; conduct thorough screenings to understand the patient's history with diabetes and risk factors; and regularly monitor glycemic control.
- Educate diabetic patients on periodontal disease including the signs and symptoms, how oral health impacts their diabetes, and what to expect in a perio exam. Recommend regular oral hygiene and bi-annual exams, and promote health lifestyle to reduce A1c, blood pressure, and cholesterol.
- Collaborate to develop best practices and clinical guidelines for treatment and care of diabetic patients, bringing together the American Dental Association, American Diabetes Association, physicians, dentists, and other caregivers.
- Promote cost analysis and implications of oral health in connection with diabetes to employers, payers, policy makers, and patients. By advocating these concerns, we have a better chance of seeing periodontal treatment covered by medical insurance, and greater incentive to drive preventive care.

The Center for Disease Control (CDC) reports they get calls every day from state dental directors asking them for recommendations and protocols on treating diabetic patients –and the CDC has nothing to offer. We have a vital call to action to develop best practices to improve care for diabetic patients and help reduce the onset of disease.

- Help develop diabetes certification programs for dental providers to learn the best ways to care for diabetic patients. Additionally, dental educators should encourage integration of medical and dental curriculum with respect to diabetes.

Joseph Errante, DDS
Vice President, Blue Cross Blue Shield of Massachusetts

Total Health Solution - Potential Future of Dental Benefits

For this Institute for Oral Health focus group, Dr. Joseph Errante introduced the payer's perspective on strategies to explore to improve dental care coverage so that it more effectively meets the health needs of our nation's public. He spotlighted the case study of an innovative Total Health Solution developed by Blue Cross Blue Shield of Massachusetts (BCBSMA) that explores the possibilities of improving medical outcomes by integrating oral health and overall health in care and coverage models.

How dental treatment saves money

Dr. Errante began by emphasizing that scientific research has demonstrated the high risk health impacts associated with periodontal disease including diabetes complications and coronary artery disease. Additionally, BCBSMA claims data noted measurable cost savings for members with these conditions who sought dental treatment. For example:

75% of adults over age 35 will be affected by periodontal disease.

- Diabetes – 2003 claims data showed that across a population of almost 15,000 diabetic members, those who received dental prophylaxis and/or periodontal treatment had $144 per month lower medical costs than members who did not seek treatment. 2008 data showed an $68 per member per month difference in costs. The 2003 and 2008 data had cohorts made of members with different disease levels. the members with severe diabetes were transitioned from the Diabetes group in 2003 to the Coronary Artery Disease group in 2008.
- Coronary Artery Disease (CAD) – Claims claims data showed that CAD members who received dental prophylaxis and/or periodontal treatment had $238 per month lower medical costs than those with no treatment. 2008 data showed a $488 per member per month difference in costs. The groups had membership changes from 2003 to 2008 with more of the severe diabetics being included in the CAD group.

Promoting proactive health management

The goal of the BCBSMA Total Health program has been to "provide long term value to employers by leveraging analysis of combined medical and dental claims data to create individualized plans that include strategies focusing on education and outreach to improve the health and productivity of employees." The program focused on a sequential approach of key objectives:

1. Identify at-risk members – Mine data from medical and dental claims, disease management participation, and Personal Health Assessments (PHA) to identify conditions and focus resources on members who are not receiving appropriate dental care.
2. Promote education and outreach – To help influence healthier behaviors, the program reached out to at-risk members –via personalized letters; phone campaigns to members with diabetes or CAD; specialized call centers to support diabetic members; and OB-GYN provider partnerships to reach pregnant members-- to provide education about oral health care, disease management and prevention.

3. Support at-risk members with personalized benefits – Beginning in 2007, the program has offered at-risk members condition-specific dental benefits to help remove cost barriers and encourage them to get regular treatment. The enhanced plans offer 100% coverage for non-surgical periodontal treatment and the required ongoing maintenance care. These enhancements are offered free of any deductibles and without impact to available calendar year maximums.

From knowledge workers to manufacturing, increasing productivity and reducing absenteeism is a vital concern, so there is significant value in delivering a plan with focused care that leads to healthier employees and lower cost of care over their lifetime.

Success highlights of the Total Health program

As a proactive solution toward improving the overall health of at-risk members, the Total Health program has seen the following successes:

- Increase in at-risk members dental access – Members with personalized, enhanced benefits have been seeking regular dental treatment, including 55% of Coronary Artery Disease members; 53% of diabetes members; and 60% of pregnant members.
- Valuable behavior changes – The increase in at-risk members accessing preventive dental treatment represents an important behavior change, up 37% after the focused outreach campaigns.
- Early intervention is reducing costs – Members who sought the earliest intervention and periodontal treatment have shown the greatest changes in health costs.
- Positive feedback from providers – Across the dental and medical community, providers have been very enthusiastic about the program. Indeed it provides a revenue enhancer for providers, but more importantly, at-risk people who need dental care are getting valuable preventive services and early interventions that help reduce the risks associated with their other health conditions.

While it is difficult to scientifically prove that the reduced medical costs are the result of the additional dental care alone, Dr. Errante believes that they are making valuable strides through clinical care, members' behavior change, and members' understanding of how their daily behaviors and lifestyle can impact their overall health. Employers see the value of reduced overall healthcare costs and engagement of their at-risk employees in health behaviors that results in more productive, happier employees.

Possible future of dental benefits

As a further step forward, Dr. Errante introduced potential changes we may see down the road for how oral health care may be represented in benefits plans. He noted a few highlights, including:

- Integration of dental into medical plans – As oral health special interest groups are placing a spotlight on key health concerns, they are having increasing influence on proposals for healthcare reform. As such, it is likely that services such as the treatment of oral infection and inflammation will become a standard part of medical plans, and the coverage for the surgical repair of dentition will be the supplemental "Dental insurance" of the future. Some carriers are working on the administrative infrastructure to enable this to happen.

- Integration into medical plan pay-for-performance – Upcoming changes may bring dental providers into the care circle around patients. An example might be the possibility of pay for performance programs rewarding dentists for their role in helping to manage blood glucose levels in diabetics (HbA1c).

- Potential impact on oral health benefits by the benefits industry – Dr. Errante noted we are reaching "a tipping point" with dental coverage. With Federal Health Care Reform and the likely transition from an employer decision maker to a consumer decision maker on the purchase of dental benefits, the value proposition of dental plans will change. Today the typical annual maximum is about $1,000 - $1,500, for which Dental Plans in some regions of the country charge as much as $400-450 per year in premiums for. As the premiums increase, employers are looking for more cost effective alternatives. As consumers' perception of the economic value of these plans goes down, they will look for alternative solutions that provide the value they are searching for. This will require the dental benefits market to move toward market segmentation with specialized plans for people in different life stages. To sell insurance to consumers, we will have to be able to deliver more value to them.

> *"Because of trends in costs and consumer needs, I think we're going to see more benefits innovation in the next 5 years than we've seen in the last 50 years –including life-stage market segmentation."*
>
> *–Dr. Joseph Errante*

Dr. Errante noted that we often become so focused on what we already know and do, and obstacles to change, that we don't allow ourselves to imagine the opportunities and possibilities. Yet "g*reat breakthroughs have come through our nation's ability to imagine the future –particularly when we were faced with what looked like insurmountable problems*."

His sentiments were echoed by Dr. Helgeson who added that our culture, instead of being creative and inventive, often focuses more on efficiency and segmented profitability, looking at what we already do and exploring how to do it in less time, for less money. But, as he said, "*if we think we're going to lead the world simply by doing old stuff quick and cheaper, we will never get there*."

Panel Discussion Highlights

In this Institute for Oral Health focus group on their 2010 theme "Oral Health in Healthcare Reform", the panel of experts shared presentations and open forum discussion with the following highlights…

The challenge of staffing dentistry for underserved populations

Dr. Maria Ryan noted surveys that have looked at factors influencing career decisions of graduating dental students. While many young dentists have a vision of building their own lucrative practice, it is often driven by the pressure of tremendous dental school debt. In fact, through her own experiences as well as research, Dr. Ryan emphasized that many early career dentists really enjoy community outreach to provide care to underserved populations, but "*other pressures may push them in a different direction, at least when they start*." She offered that dental school admissions should proactively go looking for candidates who have a passion for supporting underserved populations.

Dr. Michael Helgeson countered that while a large percentage of people may begin dental school with more altruistic intentions to serve their community, by the time they graduate they have been inundated with peer pressure from colleagues, family, and friends to pursue the traditional private practice model of "being a dentist." He noted that those who are interested in caring for special needs populations always "have a spark" most often fueled by personal experience: almost every dentist and dental hygienist in his Apple Tree Dental system has a disabled brother or sister, or a parent in a care facility, or they worked in a nursing home while they were in school, or they were previously a social worker. He added that:

> *"People in dental school are expecting to earn a high income and run their own business, own a boat, etc. They have a stereotype about what the world of dentistry is all about."*
>
> *–Dr. Michael Helgeson*

> *"Every one of our dental team has stories like that, and they are able to do this work because Apple Tree has an organizational structure that makes it possible. If those dentists had to start a new nonprofit of their own and face the complexities Apple Tree has already dealt with –such as forming a board, learning all the state regulations, hiring lobbyists, etc.-- it would be insurmountable for them. One of my goals is to create scaled organizations that have enough management depth so that new dentists can come in and earn enough to pay their student debt."*

Group participant Meg Booth, MPH noted that within the dental community, there is a stigma in being a Medicaid provider ("you're considered a failure"). The peer pressure creates a very real barrier that has little to do with financial issues and is more about credibility and how one is seen as a dental professional.

As director of clinical research at Stony Brook's School of Dental Medicine, Dr. Ryan added they are the largest Medicaid provider in New York, in part because very few practitioners will take Medicaid –not because of any stigma, but because the cost of living on Long Island is extremely high. Many dentists find they cannot serve Medicaid patients and still make a living.

How to decide about transitioning from a mobile service to a satellite clinic

As demand in certain areas increases for visits from mobile dental units, it raised the question about whether providers should consider setting up a satellite clinic at certain sites to replace the repeated mobile visits. In theory it sounds good, but most often, the economics don't weigh out. Dr. Helgeson advised that the decision to make that transition is based on the economics of the infrastructure of the site. For example, it costs about $75,000 for a single operating mobile dental unit. For a satellite clinic to be a good investment, the unit needs to be used at least three days a week. Thus, it is important to evaluate how much dental care is needed at a specific location, and whether it makes sense for the facility to allocate dedicated space for a clinic.

Most often, it would not be a cost-effective decision. For example, a typical nursing facility has about 100 residents who are seen by a dentist every 3 weeks. The facility provides a room for the mobile dental visits, and that space is used for other purposes the rest of the time. Given that most facilities have precious little office and meeting space, which they rely on to generate revenue through patients or administration, it would be a waste of money to reserve a room for a dental clinic that is used only a few times a month.

Similarly, for the dental providers, it is important to get the most value out of expensive equipment. With the mobile units, equipment is used and maintained every day at different locations. If, for example, an x-ray machine, which needs frequent inspection, sits unused most of the month, it would be too costly to waste that resource. As Dr. Helgeson emphasized:

> *"I've looked at places all over the planet and if you compare your average nursing home dental office with Apple Tree's clinic or mobile unit, there's just no comparison. Usually what happens is that someone donates a bunch of junk, there's not adequate lighting, no good infection control or x-ray procedures, and so on. We're able to have a state of the art mobile unit because we use it every day."*

Dealing with the challenge of limited dental coverage for special needs patients

As Dr. Maria Ryan had been spotlighting the challenges of providing the necessary scope of oral health care for patients with diabetes, she suggested that practitioners ask themselves where their real focus lies: on reaping the economic benefits of dentistry or creating the best experience for their patients.

For example, some dentists may consider that they can put in five implants in the time it takes to talk through oral health concerns with a diabetic patient. Yet that person with diabetes needs to be educated on how to better manage the risks of their condition –in ways that are healthier and more cost-effective. Who's going to help them if their dentist won't?

> *"I think the only way this is going to be implemented is with the help of the insurance carriers. Unless there's reimbursement, it's all dead in the water."*
>
> *–Dr. Maria Ryan*

Speaking from the payer's perspective, Dr. Errante introduced that as awareness grows across the healthcare community and the public on the connections between oral health and overall systemic health, it will drive improvements toward more integrated insurance models. Granted, he said:

"*Everyone has a ton invested in the current models, and this change would take a lot of investment and a lot of risk. For the top carriers such as Blue Cross and Delta Dental, change and upheaval is not necessarily good when you're number one. When you're number two or three, change presents opportunity, but when you're number one, it brings more risk.*"

Dr. Errante is trying to drive Delta Dental plans toward more integration with medical because it makes the most economic sense. He noted that the control of infection and inflammation is going to become part of the medical plan to shift the model of dental insurance simply being a financial exchange. He explained that when dental insurance was initiated in the 1950's, it was called a "pre-paid dental plan" – primarily because it did not insure against anything but rather pre-paid for care that would probably be needed. In our current system, when people invest in insurance, it only covers specific services. What we need is a model in which insurance covers what makes the most sense and value for a given person's health.

Dr. Helgeson added that the current system pays by treatment code, "which incents just delivering what the codes are and delivering as many as you can, creating a bizarre set of incentives." Furthermore, the pricing doesn't cover some of the most important services needed.

For example, in caring for people with disabilities, one of the most important services involves taking the time to properly assess and address their behavior issues both in terms of treating them and managing preventive care with their caregivers. "*Yet this is not reimbursed in most states, while instead we pay billions of dollars per minute for implants and certain procedures. At the provider level, it's a very flawed mechanism*."

"Our current system doesn't really align with our professional duty –so we need to use our mind and our skills and our team to do what's best for the patient."

–Dr. Helgeson

To promote change, Dr. Helgeson shared the perspective he brings to his practice: it starts by thinking about what the patient needs for optimal care; then taking it up a notch to look at what the care team needs in terms of optimal working conditions to perform the very best services for the patient. Then it's time to ask -- who should pay?

Although typically the government pays for care on some level, in order to gain greater support for patients, Dr. Helgeson suggested we need a very dramatic paradigm shift in our country's agenda for its public. In –ostensibly-- looking out for our good, the government invests the bulk of our wealth in a high level vision focused on our military might. However, we might be better served by investing in building a healthier, more self-sustaining society. Toward that end, Dr. Helgeson offered an inspiring call to action:

"I hope that our country can get to a place where everyone's healthcare is considered as important as defending us from external threats. If our government had had to go through these kind of problems [what healthcare providers face] when they were developing nuclear weapons, we wouldn't even have little tiny bombs! We sent people to the moon in the 1960's, with a fraction of the computer technology we have today –we did that as a country—and we can do this. Admittedly, many providers are comfortable with the current model or they feel their hands are tied because of how their systems are set up, but ultimately, everyone wants to do the right thing."

Additional Participants

Mary Ellen Young, RDH, MPH

Director, Institute of Oral Health

Meg Booth, MPH

Deputy Executive Director, Children's Dental Health Project

At the Children's Dental Health Project (CDHP), Ms. Booth manages policy efforts to improve the health and healthcare systems for children. Prior to joining CDHP, she served as a Policy Analyst for children with special healthcare needs and early childhood issues at the Association of Maternal and Child Health Programs. Her background includes working to educate policy makers on child health issues at the local, state, and national levels.

Martha Somerman, DMD, PhD

Dean, University of Washington School of Dentistry; Professor, Departments of Periodontics and Oral Biology; Institute for Oral Health Advisory Committee

Dr. Somerman is dedicated to innovating dental education curriculum and access to health care. Her NIDCR/NIH funded research group focuses on understanding mechanisms controlling the development and regeneration of the dento-alveolar complex with the long term goal of devising predictable therapies to regenerate oral craniofacial tissue. Dr. Somerman is a fellow of the American Association for the Advancement of Science.

2010 IOH National Conference